DOCUMENT RESUME

ED 162 050 CE 012 032

TITLE Basic Workshops for Medical Record Clerical Personnel.

INSTITUTION Intermountain Regional Medical Program, Salt Lake City, Utah.

NOTE 44p.; Not available in hard copy due to thin type in original document

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.

DESCRIPTORS Accreditation (Institutions); Adult Vocational Education; *Cluster Grouping; *Confidential Records; Curriculum Guides; *Data Collection; Hospitals; *Indexing; *Information Storage; *Medical Case Histories; Medical Record Technicians; Postsecondary Education

IDENTIFIERS International Classification of Diseases; Standard Nomenclature of Diseases and Operations; United States

ABSTRACT

This curriculum guide is an outline of the content for basic workshop training sessions of hospital medical record personnel. Following a two-page topical outline of five content areas, there is a detailed presentation of this content as follows: (1) the medical record and its contribution to patient care (Joint Commission for Accreditation of Hospitals [JCAH] standards in medical record services, and the content, value and confidentiality of the medical record); (2) record filing systems (numbering methods, filing systems, and microfilming); (3) indexing (purpose and types of indexes); (4) introduction to the "International Classification of Diseases, Adapted for Use in the United States" (ICDA-8) and "Standard Nomenclature of Diseases and Operations" (SNDO) (principles for using ICDA and SNDO, general instructions in coding, and introduction to other terminology and coding systems); and (5) discharge service analysis (data tabulation procedure, disease classifications with definitions, and programmed service analysis worksheets of fifteen brief cases to be assigned according to hospital clinical services). A list of fifteen recommended reference books and periodicals is appended. (EM)

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BASIC WORKSHOPS FOR MEDICAL RECORD CLERICAL PERSONNEL

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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INTERMOUNTAIN REGIONAL MEDICAL PROGRAM

2

COURSE OUTLINE
BASIC MEDICAL RECORD TRAINING SESSIONS

WORKSHOP I (12 hours)

I. The medical record and its contribution to patient care.

A. History of medical record keeping.

1. Early medical writings.
2. Minimum standards for hospitals.
3. JCAH accreditation standards.

B. Content of the medical record.

1. Definition.
2. Criterion for a good medical record.
3. Component parts of the medical record.
4. Principles in forms development.
5. Review of sample medical record forms.

C. Use and value of the medical record.

1. To the patient.
2. To the physician.
3. To the hospital.
4. To social agencies.
5. To research centers.
6. To insurance companies.
7. To law offices.

D. Confidentiality of the medical record.

1. Professional ethics.
2. Patient's right to privacy.
3. Means of safeguarding the confidential information in medical records.
4. Need for hospital policies.

II. Record filing systems.

A. Numbering methods.

1. Unit.
2. Serial.
3. Modified serial unit.

WORKSHOP I - (cont'd.)

B. Filing systems.

1. Alphabetical.
2. Straight numerical.
3. Terminal digit.

C. Storage of medical records.

1. Requirements for retention.
2. Methods of retention.
3. Microfilming procedures.

III. Indexing.

A. Purpose.

B. Types of indexes.

1. Patient index.
2. Physicians index.
3. Disease index.
4. Operation index.
5. Number index.
6. Tumor registries.

C. Review of sample index cards.

IV. Introduction to ICDA-8 and SNDO.

A. General instructions in coding.

B. Statistical classification vs. nomenclature.

C. Review of frequently-used codes.

V. Discharge service analysis.

A. Definition of terms.

B. Classification of clinical services.

C. Programmed service analysis worksheets.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

STANDARDS FOR HOSPITAL ACCREDITATION - (Oct., 1969)

MEDICAL RECORD SERVICES:

PRINCIPLE: The hospital shall maintain such facilities and services as are adequate to provide medical records that are accurately documented, readily accessible and can easily be used for retrieving and compiling information.

STANDARD I: An adequate medical record shall be maintained for every person admitted as an inpatient, outpatient, or emergency patient.

STANDARD II: The medical record shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment and to document the results accurately.

STANDARD III: Medical records shall be confidential, current and accurate.

STANDARD IV: The medical record department shall be adequately directed, staffed and equipped to facilitate the accurate processing, checking, indexing, filing and prompt retrieval of all medical records.

STANDARD V: The medical record department shall maintain a system of identification and filing to facilitate the location of a patient's medical record.

(STANDARDS For Accreditation of Hospitals)
Joint Commission on Accreditation of Hospitals
645 North Michigan Ave.
Chicago, Illinois 60611

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

CONTENT OF THE MEDICAL RECORD:

Definition: A medical record is an orderly, confidential written report of the patient's complaint, history, physical examination, diagnostic findings, treatment, and final results.

Criterion for a good medical record: Every medical record must contain the necessary data to justify the diagnosis and warrant the treatment and end results.

Component parts of the medical record:

* Identification data: Patient's name, address, age, next of kin, and other identifying information.

* Consent forms: Those consent forms deemed necessary by the hospital's administration and the medical staff.

* History of the patient: Chief complaint, details of present illness, inventory of systems, past history, social history and family history.

* Report of physical findings: All pertinent findings resulting from an assessment of all the systems of the body.

> If a complete history has been recorded and a physical examination performed within approximately 30 days prior to the patient's admission to the hospital, a legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the medical staff. In such instances, an interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must always be recorded.

* Diagnostic and therapeutic orders.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

CONTENT OF THE MEDICAL RECORD - 2

* Observations: These reports should include progress notes by the medical staff and house staff, consultation reports, nurses' notes and entries by allied health personnel. Consultation reports should contain a written opinion by the consultant, based on an examination of the patient and his record.

* Reports of actions and findings: These reports should include such items as reports of pathology and clinical laboratory examinations, radiology examinations, medical and surgical treatment and any other diagnostic or therapeutic procedures, and may include any reports from out-of-hospital facilities.

* Conclusions: These should include the provisional diagnosis, primary and secondary final diagnoses, clinical resume, and autopsy report when one has been performed. A final progress note may satisfy the provision for a clinical resume in the case of normal deliveries, normal newborn infants, and patients with problems of a minor nature who require less than a 48-hour period of hospitalization.

VALUE OF THE MEDICAL RECORD:

* To serve as a basis for planning patient care;

* To provide a means of communication between the physician and other professionals contributing to the patient's care;

* To furnish documentary evidence of the course of the patient's illness and treatment during each hospital admission;

* To serve as a basis for review, study and evaluation of the care rendered to the patient;

* To assist in protecting the legal interests of the patient, hospital and medical staff; and,

* To provide data for use in research and education.

REFERENCE:

1. Standards for accreditation of hospitals (Oct.1969).

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

CONFIDENTIALITY OF THE MEDICAL RECORD:

I. Professional ethics: "The conforming to professional standards of conduct" . . . "the principles and standards which guide the right choice in our daily activities."

All medical record personnel shall hold in confidence the privileged information entrusted to them, and shall safeguard this information from unauthorized persons, maintaining at all times the confidential status of the medical record. Neither the patient nor his record should be discussed except in the line of duty. It is up to medical record personnel to be able to differentiate between privileged and unprivileged information.

"Privileged" or confidential communication is one which contains certain private information given by a patient to his physician, by a client to his attorney, or by a person to his religious advisor. Statutes relating to privileged information may vary according to the laws of the different States. Even though a state may not have a specific statute regarding confidential communications, practices have grown up from usage in states not having such statutes whereby the patient-physician relationship is observed and the patient is protected from unauthorized release of information from his medical record.

"Nonprivileged" information are those facts not related to medical treatment, such as name and address of patient, dates of admission and discharge, name of relative or friend given at the time of admission, etc. No authorization is necessary to disclose this information to persons or agencies who have a legitimate interest in this data. However, even this information should be released with care and only in response to proper inquiries. Certain data that would be considered nonprivileged in a general hospital might be confidential in a specialty hospital or in a special service of a general hospital, such as the psychiatric unit.

The names of physicians and house officers associated with a case, while technically not confidential, should be considered so; however, it is customary to disclose the names of attending physicians with their consent.

CONFIDENTIALITY OF THE MEDICAL RECORD - 2

II. Patient's right to privacy: "The patient has a right to feel confident that the privileged information contained in his medical record will be kept confidential unless he waives the privilege, or release of the information is compelled by statute, regulation or other legal means. (Guide to the Interpretation of AMRA Code of Ethics -- Code No. 2).

The individual's right to secrecy, in this case that of the patient, is based on the natural law and is derived from the very nature of man. One's right to his own secrets is universally recognized and defended as part of our natural heritage. Secrets in general are defined as "any hidden knowledge, pertaining to a person by strict right, which others may not lawfully seek to possess, use, or dispose of (i.e., reveal) contrary to the reasonable will of the owner." "Because of the necessity of procuring proper medical care, patients have no choice but to entrust their physicians with knowledge about themselves which otherwise they would not dream of divulging. They do so on the implicit understanding that their secrets are entirely safe with doctors and that their confidence as patients will in no way be used to their disadvantage. They do not relinquish their right to secrecy, but perforce allow the doctor (and medical record personnel) to share in the possession of knowledge over which they alone retain the right of any further disclosure." The right of privacy is a right to be free from the mental pain and distress resulting from the unnecessary publication of facts or pictures which reveal intimate and peculiarly personal information concerning the patient.

III. Means of safeguarding confidential information.

Patient's consent for release of information: A patient may waive his claim of privilege by giving written authorization for release of information from his medical record. When the requesting party presents this signed and dated authorization, the medical record librarian may release the information in the medical record. The consent may be given by the patient himself or by a legally qualified representative, such as the parent of a minor, the spouse, the executor or administrator of an estate, the guardian of an infant, a "committee" representing a person adjudged to be incompetent, or an agency designated by the court as guardian.

CONFIDENTIALITY OF THE MEDICAL RECORD - 3

A patient forfeits his right to the protection of the confidential information in his medical record either expressly or by implication. It is done expressly when the patient gives a verbal or written authorization to the hospital to release information to third parties concerning his stay in the hospital. Waiver of the confidential status of the information is implied where the patient takes action against the physician or the hospital for alleged malpractice or negligence. The defendants may use the medical record in their own defense.

The patient's authorization should be specific as to the information to be released and should also contain the name of the parties to whom the information may be released. A further provision should be contained absolving the hospital from liability for damage that may arise out of the release of the information requested. The authorization should be dated and witnessed.

The consent of the patient is not required when a subpoena or an order of a court or other authorized body (e.g., workmen's compensation or industrial accident board) directs that records be produced.

The physician has no legal right of control over the release of information, even in a private case. He may be consulted as a matter of courtesy and, in the event of legal action, should be consulted as a matter of prudence.

Other points of information regarding release of confidential data and consent forms will be included in the lecture on medico-legal aspects.

IV. Hospital policies for release of information.

Hospitals have the duty to safeguard the confidential information in their medical records. It is the responsibility of hospital administration that concise hospital policies in this regard be written and made available for all concerned, but medical record personnel have a more direct concern in the matter. If third parties are given the privilege of

direct inspection of medical records, this should be spelled out very specifically in the hospital policies. The hospital is responsible for providing adequate safeguards to prevent access to a patient's medical record by unauthorized persons from the time the record is initiated throughout the patient's hospitalization, and after his discharge. These policies should specify in what form information will be released, whether by means of summaries or standard abstract forms, or, when more information is required, by a duplicated copy of the discharge summary or pertinent parts of the record. Some hospitals submit photocopies of an entire medical record when an abstract or summary is requested. While such a practice takes less time than to make an abstract, it may be dangerous because information may be sent which will lead to complications.

By way of summary, the medical record as an order of business is the property of the hospital, while the personal data contained in the record are considered as a confidential communication in which the patient has a property interest. When releasing any information, the medical record personnel should ascertain whether the record is to be used as an impersonal document or a personal document. If it is to be used as personal information, written authorization must be obtained from the patient, and as a matter of courtesy, from the attending physician. An authorization for release of information should be honored only for the period of hospitalization covered by the dates on the authorization. If the record is to be used for purposes of research or other scientific investigation, permission is not necessary from the patient nor from the attending physician, unless the information is to be published. In such an instance it is desirable to secure the consent of the attending physician.

It is of major importance for medical record personnel to remember that an authorization for release of information, signed by the patient or other responsible party, is always necessary when the confidential information is to be released in the absence of any specific law to the contrary.

REFERENCES:

1. "Professional ethics," Huffman, Manual for Medical Record Librarians, pp. 134-140, 147.

CONFIDENTIALITY OF THE MEDICAL RECORD - 5

2. "Confidential Communications," Huffman, Manual, pp. 418-419.
3. "Legal Aspect of Medical Records -- Summary," Huffman, Manual, p. 455.
4. "Security and release of medical information," AHA Guide to the organization of a hospital medical record department, pp.51-58.
5. "Ethical aspects of medical records," Sister Rose Agnes, FSPA, RRL, Medical Record News (Dec.1962), p. 249.
6. "Legal aspects of patient photography," James E. Ludlam and Charles F. Forbes, Hospital Forum (March,1962), p.31.
7. "Medical Secrecy: Some moral aspects," John J. Lynch, S.J., Linacre Quarterly (Feb. 1962), p.9-20.
8. "Ethics for medical record library personnel," Mary Ellen Twitty,RRL, Journal of the American Association of Medical Record Librarians (Aug.1956), p. 185.
9. "Code of Ethics for the Practice of Medical Record Science," editorial, Journal of the American Association of Medical Record Librarians (Dec.1957), p.232.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

NUMBERING METHODS

1. UNIT NUMBERING: This is the method in which the patient receives a number on his first admission to the in- or outpatient department of the hospital, and retains that number on all subsequent admissions to any department of the hospital. All admissions are filed together under one number and in one folder.

2. SERIAL NUMBERING: In this method, the patient is assigned a new record number for each admission, the number always being the next unused number. The use of a serial number results in the filing of a patient's record in one or more places in the file, depending on the number of times he is admitted to the hospital.

3. SERIAL-UNIT NUMBERING: This is a modification of the unit and serial numbering methods, in which the patient receives a new number at the time of each admission to the hospital, but his medical records are brought forward into a unit record and filed under the latest number.

Another form of the modified method is used in the centralized system of filing, in which case the patient may have several out-patient records filed under one out-patient number, but at the time of his first admission to the hospital as an in-patient he will receive the next unused in-patient number. All of the out-patient records will then be brought forward and filed under his in-patient number, and this is the number he will retain for all subsequent out-patient or in-patient admissions. (This is explained further under the section on centralized filing).

REFERENCES:

1. "Numbering and filing medical records," Huffman, Manual for Medical Record Librarians, pp. 207-246.
2. "Record filing system," A.H.A. Guide to the organization of a hospital medical record department, pp. 11-17.
3. "Color in serial numbering," Marjorie Balmer, RRL, Medical Record News (Oct.1963), p. 197.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

FILING SYSTEMS: I

I. Centralized System.

This is the filing system in which all the medical records of a patient, whether inpatient or outpatient, are filed together in one location. The unit method of numbering is recommended for the centralized system of filing.

A modification of this system is used in those hospitals which use one set of numbers in the outpatient department and another set of numbers for inpatients. At the time of the patient's first admission to the hospital as an inpatient, he will be assigned the next unused number and his outpatient records will be brought forward under this new number. Under the centralized unit system, all of his subsequent outpatient and inpatient records will be filed under the same number.

II. Decentralized System.

Under this system, the inpatient records and the outpatients records are filed independently in their own departments, and there is no connection between the two filing systems. Because of the time, personnel, and cost involved, this system is being replaced in many hospitals by the centralized system.

Any of the three numbering methods may be employed in this system of filing. Even if a unit method of numbering is used in which the patient is assigned the same number in both the inpatient and outpatient departments, but yet the medical records are filed in separate locations, this would still be considered the decentralized system.

REFERENCES:

1. "Numbering and filing medical records," Huffman, Manual for Medical Record Librarians, pp. 215-217.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

FILING SYSTEMS: II

I. Alphabetical. (Petient index file)

The following rules will assist in alphabetical filing:-

a) Transpose names of patients, placing surname first, then given name followed by middle name or initial, and file in strict alphabetical sequence. Individual name prefixes are considered as part of the surname (ex: L'Engle as Lengle).

b) Hyphenated surnames of individuals are treated as one word (ex: Mary Duff-Gordon as Duffgordon, Mary).

c) Names beginning with St., as St. George, are filed as Saint.

d) The legal name of a married woman together with her given name is the one considered for filing (her husband's name may be indicated for purposes of identification).

e) Arrange cards in alphabetical order like that of words in a dictionary, following letter by letter to the end of the name and then by given name and initials.

f) If there is more than one person of the same surname and given name, the cards are arranged alphabetically by middle initial or middle name.

II. Numerical.

A. Straight numerical filing: A system in which consecutively-numbered folders are placed in a file in exact chronological order. Tabs on the guides used with straight numerical systems are usually staggered, rather than placed in a straight line, one behind the other, to make all guides easily visible at a glance.

B. Middle digit filing: In this system, the number of a given document or folder is divided into groups of two digits for filing. In working with folder number 273684, it would be divided into two-digit groups and read 27-36-84 for use in middle digit filing. The clerk files first according to the middle digits (36), referred to as the primary digits; next, the digits on the extreme left-hand side (27), the secondary digits; and last, the two digits on the extreme right-hand side of the number (84), the tertiary or final digits.

C. Terminal digit filing: In this system, as in middle digit filing, the file folder number is divided into groups of two digits each for ease of reading and to speed the filing and finding operations. A folder numbered 384723 would be divided to read 38-47-23, or from right to left, into its primary digits (23), its secondary digits (47), and its tertiary or final digits (38). It would be filed by working with these digits in that same order. This system is based on a mathematical principle which assures an even distribution of records as they are added to the file. Usually the entire file is divided into a hundred sections, 00 to 99. Into these sections the records go according to their last two digits. Records are then assigned to subdividions of these major sections by their middle digits. If the file is a very large one, the two next digits are used, making 10,000 subdivisions in the entire file. If the file is smaller, a single middle digit is used, giving 1000 subdivisions.

To further clarify this system, folder number 38-47-23 would be filed behind guide 47-23. It would be filed on the shelf between folders 37-47-23 and 39-47-23. Folder number 38-47-24 would be filed behind guide 47-24 and between folders 37-47-24 and 39-47-24.

Terminal digit filing has one outstanding advantage for hospitals of all sizes. It greatly reduces the possibility of misfiles. By compelling clerks to concentrate on one or two digits at a time, it lessens transposition and other reading errors.

REFERENCES:

1. "Numbering and filing medical records," Huffman, Manual for Medical Record Librarians, pp. 207-246.
2. "Record filing system," A.H.A. Guide to the organization of a hospital medical record department, pp. 11-17.
3. "36 1/2 Hours to terminal digit filing," Bertha Petrak, RRL, Medical Record News (Feb.1966), p. 27.
4. "The big move in Memphis," Gladys M. Demster, RRL and Emory Grinnell, Medical Record News (Oct.1964), p. 201.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

MICROFILMING

By definition, we are referring to the process by which the patients' medical records are transferred through a photographic procedure to rolls of 16 mm. film, and either stored in that form or mounted into jackets on an individual patient basis. In addition, there are other forms in which the filmed data may be stored, such as the microfiche which will store as many as 400 microfilmed documents on seven sheets of micro-folio. It is estimated that records on microfilm take up less than 2% of the space used to maintain the original records.

Consideration should be given at each individual hospital as to its preservation of medical records on a permanent basis. Hospital policy, based on the statute of limitations, and the recommendations of the American Hospital Association on retention of medical records, and the needs of the medical staff, should specify what to keep, for how long, to what extent, and by what means. If microfilming is the method of choice, a decision should be reached on a schedule for microfilming -- whether the procedure should be done entirely by hospital personnel, entirely on a contract basis with an outside company, or by both in cooperation.

To eliminate some of the more common problems which might be encountered, the following precautions are being enumerated:-

1) The medical records of minors should be microfilmed in their entirety, inasmuch as the statute of limitations does not begin to run until after the child has attained his majority.

2) If the microfilming schedule includes medical records of patients discharged within the period of the statute of limitations, it may be advisable to microfilm all portions of the medical records, including nurses' notes.

3) If there is a State law that original records be retained, they should not be mutilated after microfilming.

4) Special emphasis should be placed on the preparation of the medical records for filming so that all errors will be detected and corrected before being filmed. Staples and other fasteners should be removed. The sequence of the reports should be checked thoroughly so they will be filmed in proper order. Superfluous material should be

removed from the record, such as irrelevant correspondence or carbon copies of reports in addition to the original. A thorough check should be made for accuracy of names and hospital numbers.

5) If the microfilming procedure is carried out at the hospital, make certain that the reverse side of reports are filmed in those instances when a report has been continued on the reverse side of the paper. Important information can also be lost by the overriding of material caused by feeding reports into the printing machine too quickly one after the other, or by feeding sheets of laboratory reports into the machine before separating the overriding individual reports.

6) Careful editing should be done before the original medical records are destroyed.

Filing of microfilmed records:

Microfilming on rolls is usually considered satisfactory in hospitals using a serial or serial-unit numbering system in which the records are seldom used after discharge of the patient.

The unit type of jacket or microfiche containing the medical record of a single patient is recommended in hospitals using the unit numbering system, and in institutions in which the medical records are used extensively for scientific purposes. Some hospitals file these jackets in drawers, although many of the larger hospitals file them on shelves built for that purpose, just as they file medical record folders on shelves.

REFERENCES:

1. Huffman, Edna K., RRL, Manual for Medical Record Librarians, 5th ed., pp. 261-276.
2. Guide to the organization of a hospital medical record department, pp. 59-61.
3. "Film your record and have it too," Myra R. Enkelis, RRL, Medical Record News (Oct., 1964), p. 189.
4. "Mistakes in microfilming," Anna M. Pajala, RRL and Stuart A. Brody, Ph.D., Medical Record News (Oct., 1963), p. 199.
5. "Retaining Records: how long?" Illinois Association of Medical Record Librarians, Medical Record News (Feb., 1963), p. 9.
6. "Microfilm or storage?" Mildred Barton, RRL, Medical Record News (Feb. 1963), p.13.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

INDEXING

Purpose: To facilitate the location of required information.

The primary function of the hospital, which is the proper care of the sick and injured, necessitates having information maintained in an accessible manner. The indices in the medical record department provide the means for retrieval of necessary data from medical records.

Types of indexes:

1. PATIENT INDEX - key to the location of the medical record according to the name of the patient. This index is arranged in alphabetical order, or according to phonetic code.

2. DISEASE INDEX - means of producing the medical record by way of diagnosis. This is maintained in numerical order according to the code numbers of the disease, and used for purposes of study and research, as well as statistical data pertaining to medical care in the hospital.

3. OPERATION INDEX - means of locating information regarding surgical procedures performed in the hospital.

4. PHYSICIANS' INDEX - means of producing the medical record by the name of the physician or the code number of the physician. The index may be maintained on cards or in a loose-leaf ring binder. The cards or sheets may be arranged either in alphabetical order according to the name of the physician, or in numerical sequence according to the physician's code number.

5. NUMBER INDEX - key to the control of patients' hospital numbers. This type of index is not always maintained in hospitals that keep a patients' register in the admitting office. The number index is more essential if the unit method of numbering is used. It may be recorded on cards or in a loose-leaf book which could be bound at the end of the year to prevent loss.

INDEXING - 2

6. TUMOR REGISTRY - means of locating pertinent information on diagnosis, treatment, follow-up, and end results of all patients with a diagnosis of cancer. Although the data collected is basically the same in all registries, it may vary according to the requirements of the State or region involved, insofar as the philosophy of the Registry, its format, and the extent of participation are concerned.

REFERENCES:

1. "The patients' index," Huffman, Manual for Medical Record Librarians, pp. 247-260, 315.
2. "Disease and operation indexes," Huffman, Manual for Medical Record Librarians, pp. 308-310.
3. "Indexing procedures," Huffman, Manual for Medical Record Librarians, pp. 315-340.
4. "Indexing according to ICDA," Huffman, Manual for Medical Record Librarians, pp. 351-352.
5. "Indexes," AHA Guide to the organization of a hospital medical record department, pp. 43-50.
6. "Good indexing is simple indexing," Mary E. Converse, RRL, Medical Record News (Feb.1966), p. 23.
7. "Manual for cancer programs," Department of Professional Services, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.
8. "Handbook for Cancer Registry Secretaries," American College of Surgeons.
9. "Computerized Tumor Registries: An experiment in patient care," Charles R. Smart, MD, FACS, Stanley J. Altman, MD, and Virginia Moslander, Ca - A Cancer Journal for Clinicians, 19:8-17, 1969.
10. "An approved cancer registry," June M. Wallace, RRL, Medical Record News (Aug.1956), p.188.

INTERNATIONAL CLASSIFICATION OF DISEASES, ADAPTED FOR USE IN THE UNITED STATES (ICDA-8)

ICDA-8 is a statistical classification designed to furnish quantitative disease data on groups of cases. It is published in two volumes --- the Tabular List (Volume I) contains the classification scheme of diseases, operations and related categories with distinctive code assignments for subject matters. The Alphabetic Index (Volume II) is an essential adjunct to the Tabular List and lists a greater number of diagnostic and operative terms for reference to Volume I.

Principles for using ICDA

1. The basic number of digits applied to a disease condition is three, such as 540 for acute appendicitis. In many instances, the code number will be found to have been further expanded by use of a decimal digit, .0 through .9, to amplify or permit greater detail in the classification of a disease, but these fourth digits must not be arbitrarily applied by the coder.

   Operative procedures are assigned two digits, such as 41 for operations on the appendix. Here also are decimal digits .0 through .9 which are assigned to describe the precise procedure. Again, these decimal digits are constant and may only be applied if found in the listing of operative procedures and treatments in ICDA.

2. Refer to the Alphabetical Index, Volume 2 of the ICDA. This will direct the coder to the general location in the Tabular List, Vol. 1.

3. Look consistently in the index under the disease or condition, and not the site.

4. In the tabular list, read the inclusions as well as the exclusions under each number. Use two codes if necessary to index a term correctly.

5. Study the notes at the beginning of each chapter.

6. Malignant neoplasm refers to the primary site unless otherwise directed. There are separate codes for secondary or metastatic neoplasms. The histology of tumors is not coded.

7. Birth codes are preceded by Y.

8. Conditions and other reasons for utilization of hospital services not classifiable in the main sections are included in the Supplementary Division.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

GENERAL INSTRUCTIONS IN CODING -- ICDA-8:

The Classification, arranged in seventeen main sections, deals first with diseases caused by well-defined infective agents; these are followed by categories for neoplasms, and endocrine, metabolic, and nutritional diseases. Most of the remaining diseases are arranged according to their principal anatomical site, with special sections for mental diseases, complications of pregnancy and childbirth, certain diseases peculiar to the perinatal period, and ill-defined conditions including symptoms. The last section provides a dual classification of injuries, according to the "external cause" giving rise to the injury and according to the "nature of injury," such as puncture, open wound, or burn. The numbers 800-999 have been assigned to both these categories; they are distinguished by the prefix "E" in the classification by external cause and by the prefix "N" in the classification by nature of injury. The Detailed List consists of a list of 671 categories of diseases and morbid conditions, plus 182 categories for classification of the external cause of injury and 187 categories for characterization of injuries according to the nature of the lesion.

I. Infective and Parasitic Diseases
II. Neoplasms
III. Endocrine, Nutritional, and Metabolic Disorders
IV. Diseases of Blood and Blood-Forming Organs
V. Mental Disorders
VI. Diseases of the Nervoux System and Sense Organs
VII. Diseases of the Circulatory System
VIII. Diseases of the Respiratory System
IX. Diseases of the Digestive System
X. Diseases of the Genitourinary System
XI. Complications of Pregnancy, Childbirth, and the Puerperium
XII. Diseases of the Skin and Subcutaneous Tissue
XIII. Diseases of the Musculoskeletal System and Connective Tissue
XIV. Congenital Anomalies
XV. Certain Causes of Perinatal Morbidity and Mortality
XVI. Symptoms and Ill-defined Conditions
XVII. Accidents, Poisonings, and Violence (Nature of Injury)
E XVII Accidents, Poisonings, and Violence (External Cause)
Y Special Conditions and Examinations Without Sickness

The basic number of digits applied to a disease condition is three. In many instances, the code number will be found to have been further expanded by use of a decimal digit, .0 through .9, to amplify

GENERAL INSTRUCTIONS IN CODING (ICDA-8) - 2

or permit greater detail in the classification of a disease, but these fourth digits must not be arbitrarily applied by the coder.

The following are the general headings for the Surgical Operations, Diagnostic and other Therapeutic Procedures:

01-05	Neurosurgery
06-14	Ophthalmology (Eye)
16-21	Otorhinolaryngology (Ear, Nose & Throat)
22-23	Operations on thyroid, parathyroid, thymus and adrenals
24-30	Vascular and cardiac surgery
32-35	Thoracic surgery
38-48	Abdominal surgery
50-52	Proctological surgery
54-61	Urological surgery
65	Breast surgery
67-72	Gynecological surgery
74-78	Obstetrical procedures
80-90	Orthopedic surgery
92-94	Plastic surgery
95-98	Oral and maxillofacial surgery
99	Dental surgery
A1-A2	Biopsy
A4-A5	Diagnostic endoscopy
A8-A9	Diagnostic radiography
R1	Radiotherapy and related therapies
R4	Physical medicine and rehabilitation
R9	Other nonsurgical procedures

Operative procedures are assigned two digits. Here also are decimal digits .0 through .9 which are assigned to describe the precise procedure. Again, these decimal digits are constant and may only be applied if found in the listing of operative procedures and treatments in ICDA-8.

CODING INSTRUCTIONS

STANDARD NOMENCLATURE OF DISEASES & OPERATIONS (SNDO)

Basic Principles:

1. The classification is dual. Diseases are coded by TOPOGRAPHY and ETIOLOGY (site and cause) and operations are coded by TOPOGRAPHY and PROCEDURE.

2. Topography deals with anatomical site and is divided into 11 Systems.

3. Etiology deals with cause of disease and is divided into 13 Categories.

4. First position codes are the System, Category or Procedure. Second position codes are the divisions. Third, fourth and fifth position codes are the subdivisions.

5. Master codes are control codes and must never be changed except 13 to 14, 46 to 47 and vice versa.

6. Master codes must always be completed where decimals appear in the nomenclature of disease and nomenclature of operations.

7. Incomplete codes or open end codes are recognized by the symbol . . . -

8. Master codes are used only to save space in the nomenclature.

9. Incomplete codes are completed with either site or region numbers, whichever the case may be.

10. Incomplete codes or open end codes must never appear in the disease and operation indexes. They must always be converted to complete codes.

11. Decimal digits follow etiologic codes to indicate end processes of disease and denote structural and functional change. They may be used arbitrarily whenever indicated.

12. The index is always the first approach when looking for a diagnostic code number.

13. The number in italics in parentheses in "The Nomenclature of Disease" is the International equivalent.

STANDARD NOMENCLATURE - 2

14. The number in parentheses to the right of the operation in the operation index refers to the procedure in the "Nomenclature of Operations".

15. The number in parentheses to the right of the diagnosis in the index refers to the etiologic category in the "Nomenclature of Diseases" where the diagnosis will be found.

16. Supplementary terms are never used as a part of the code number. They must never replace either etiology or topography.

17. Supplementary terms are never used as diagnosis. If the diagnosis cannot be stated use Y00-Y00 Disease Undiagnosed. Change as many of the first three digits as possible to specify site. For example, 410-y00 Undiagnosed disease of the heart.

18. Eponyms are listed alphabetically in the Disease and Operation indexes.

19. The letter "y" is used to:

(1) Indicate the undetermined factor in a code
(2) Indicate a suspected diagnosis when it follows the etiologic code
(3) In the operation section, to indicate alternate method of approach.

20. When a disease is due to one of several causes the cause must be specified by the Physician.

21. Operations are classified into 9 Procedures.

22. With Category 8, decimal digits follow basic codes.

23. Basic codes are those found on Pages 72 to 78 in the etiologic section of the Nomenclature.

24. Always check Category 8 to determine the basic code before a digit is added to indicate the end process of a disease.

25. Metastasis is indicated by .0

26. Metastatic site is indicated by the letter I

27. Grouping is defined as a collection of numbers having some mutual relation or dependence.

STANDARD NOMENCLATURE - 3

28. In the maintenance of the disease and operation index, cards are arranged in strict numeric sequence according to the topographic code number.

29. The smallest numeric possibility of the etiologic and topographic classification is six. The greatest is 12. If a behavior letter is used the largest number is 13 components.

30. Letters A to I are used with the neoplasm codes to indicate behavior of the neoplasm.

31. The 9 and X Categories are the Unknown etiologic categories and Y is the Undetermined etiologic category.

Note — For more complete instructions in coding, either according to the Eighth Revision-International Classification of Diseases or the Standard Nomenclature of Diseases & Operations, it is recommended that a study be made of the references listed below.

REFERENCES:

1. "The International Classification of Diseases," Huffman, Manual for Medical Record Librarians, pp. 341-352.
2. "The Standard Nomenclature of Diseases and Operations," Huffman, Manual for Medical Record Librarians, pp. 277-314.
3. International Classification of Diseases, Adapted, Vol.1 and Vol.2, Public Health Service Publ. No. 1693.

BASIC MEDICAL RECORD TRAINING SESSIONS
WORKSHOP I

INTRODUCTION TO OTHER TERMINOLOGY & CODING SYSTEMS:

I. Current Medical Terminology (CMT).

Current Medical Terminology is a system of reference for the selection of preferred medical terms including certain synonyms, and generic terms. All preferred terms are supported by concise definitions to establish the meaning of the terms. In addition, key-words, descriptors, and abbreviations are listed for the categorization of data as in the preparation of medical reports. It is not a replacement for the Standard Nomenclature of Diseases.

The primary purpose of this handbook is to assist the physician in finding the appropriate diagnostic term for use in a specific case. To assist him in making a selection, each term is supported by a brief description of the disease together with the signs and symptoms that can be expected with such a diagnosis. Synonyms, eponyms, and other nonpreferred terms are cross referenced to the preferred disease term. The chief value of this handbook to the medical record personnel is that it will assist in finding the preferred term for coding and indexing if the physician has used a term on the medical record that cannot be found in SNDO or ICDA.

II. Systematized Nomenclature of Pathology (SNOP).

In the Systematized Nomenclature of Pathology system, the medical terms and code numbers that match them are arranged in four groups: Topography, Morphology, Etiology, and Function (T, M, E, F). The four groups represent the subjects of anatomy, pathological morphology, causes of diseases and functional disorders and states. Though the largest percentage of diagnoses are pathological, the system meets the needs of classifying and coding clinical diagnoses. Any term from any of the four groups has a four digit number assigned to it.

This system, published by the American College of Pathology, has been used for years in departments of pathology, but it was not until January, 1968 that it was applied to medical records.

REFERENCES:

1. Current Medical Terminology, 3rd ed., publ. by American Medical Association.
2. "Current Medical Terminology," Huffman, Manual for Medical Record Librarians, pp. 311-312.
3. "Hartford Hospital first to adopt S.N.O.P. code in medical records," Hospital Administration journal.

DISCHARGE SERVICE ANALYSIS
Procedure

I. Introduction.

The principal source of medical statistical data in the hospital is the medical record. The analysis of this data provides the necessary appraisal of the efficiency of the hospital and medical staff. Two types of reports stem from this valuable information: (1) reports required by the Governing Board, the Hospital Administrator, and the Medical Staff; (2) reports requested by several related agencies, including the licensing and accrediting agencies. One important point to remember is that if statistics are to be comparable, they must be assembled on the same basis in all hospitals. A daily cumulative tabulation of data will provide the most accurate reports, and this information can be transferred to the monthly report forms at the end of the month, which in turn can serve as the basis of the figures needed for the semi-annual and annual report forms.

II. Methods of collection.

A. Assignment according to final diagnosis.

All hospitals, irregardless of size, should enter data under at least the minimum basic services of Medicine, Surgery, Obstetrics, and Newborn. Many factors create variations in the assignment of patients to clinical services for treatment; however, service assignments that are based on the final diagnosis according to a definite pattern will give a consistent picture of the work done in the hospital without specialized services. In a hospital without any departmentalization of the medical staff, an arbitrary classification of discharged inpatients by diagnosis and procedure provides a general picture of the kinds of patients who have received inpatient services. In such a situation, patients who have had surgical operations performed are often assigned to Surgery, and those whose treatments have not involved surgery or obstetrical care are assigned to Medicine. It is recommended by the Joint Commission on Accreditation of Hospitals that a hospital of 75 beds or over have as a minimum the three basic departments, i.e., medicine, surgery, and obstetrics. In addition, a newborn service is necessary for statistical purposes because infants newly born in the hospital should not be grouped in the three basic departments even though the newborn infant may be cared for by the obstetrician rather than a pediatrician.

In assigning cases according to diagnosis, it is common practice to consider the condition chiefly responsible for prompting referral or recourse of a patient to the hospital, or the condition requiring the major portion of the length of stay.

The basic services of medicine and surgery and their subspecialties are listed here for reference: -

MEDICINE	SURGERY
Allergy	Fractures
Cardiology	Gynecology
Communicable Disease	Neurosurgery
Dermatology	Ophthalmology
Gastroenterology	Orthopedics
Neurology	Otology
Pediatrics	Otorhinolaryngology (Otolaryngology)
Psychiatry	Plastic Surgery
	Proctology
	Thoracic Surgery
	Traumatic Surgery
	Urology

B. Assignment according to the organized services.

An organized clinical service is one that has a chief for the particular service, and in addition has beds assigned to the service, or admitting procedures that clearly identify the clinical service to which the patient is assigned. The Joint Commission on Accreditation of Hospitals does not recognize a general practice inpatient service. This means that whenever a general practitioner admits an inpatient for surgery, he acts as a member of the surgical service. When he admits a patient for medical treatment, he does so as a member of the medical service. In each instance, he is administratively responsible to the chief of the service named.

The discharge service analysis that provides data by organized services for the departments existing in the hospital may be expanded or contracted, depending upon the number of clinical departments. This would vary with the size and location of the hospital, the type of medical staff organization, and the type of patient accepted for treatment. (See "Disease Classification - Definitions")

III. Summary.

In either method of data collection, it is important to point out that each hospital must be consistent in its method.

DISCHARGE SERVICE ANALYSIS

Procedure - 3

The organization of hospital medical staffs is a very individual matter. In a hospital with a highly structured staff organization, physicians will have privileges only in the departments or medical staff units of their specialty, and evaluation of the functioning of each unit depends on accurate statistics about the professional care given their patients by the physicians of the unit.

In many hospitals, however, even when the medical staff has been divided into functional units, physicians may have privileges in several different units and move freely back and forth across the almost invisible department lines. In such hospitals it is more difficult to evaluate the activities of the different medical staff units which do not reflect a specialized division of labor as they do in hospitals with more highly structured medical staff organization.

It is in hospitals like these and in hospitals without an organized staff that classification of patients by type of diagnosis is done, and services are assigned to patients according to the medical staff units which would have been responsible for this care in a more highly structured organization.

DISEASE CLASSIFICATION
Definitions

ALLERGY: conditions due to hypersensitivity to specific allergens.

CARDIOLOGY: diseases of any part of the cardiovascular system, which includes the heart, conduction systems, arteries, veins, and capillaries.

COMMUNICABLE DISEASE: illness due to a specific infectious agent or its toxic products, which arises through transmission of that agent or its products from a reservoir to a susceptible host, either directly or indirectly.

DERMATOLOGY: diseases and conditions of the skin.

GASTROENTEROLOGY: diseases and conditions of the digestive system except the anus, rectum and sigmoid colon.

GYNECOLOGY: diseases and conditions of the female generative and urinary organs, and the rectum if it is a part of the disease syndrome of the generative organs. Diseases of the breast and diseases and conditions associated with pregnancy and the puerperium are not included.

MEDICINE: diseases and conditions treated by the administration of interr l remedies except those which are assigned to a subspecialty.

NEUROLOGY: diseases of the central, peripheral, and sympathetic nervous systems, except those requiring operative treatment.

NEUROSURGERY: diseases of the central, peripheral, and sympathetic nervous systems treated by surgical measures.

NEWBORN: (alive at birth) to include only infants born alive in the hospital. Infants born at home or on the way to the hospital should be entered under Pediatrics.

OPHTHALMOLOGY: diseases, conditions, and injuries of the eye and supporting structures regardless of types of therapy (except tumors, venereal diseases, and some communicable diseases).

OTORHINOLARYNGOLOGY (aka otolaryngology): diseases of the ear, nose, throat, larynx, pharynx, nasopharynx, and tracheobronchial tree.

DISEASE CLASSIFICATION - 2

OBSTETRICS: diseases and conditions of pregnancy, labor, and the puerperium, whether normal or pathological, pregnancy commencing with conception and the puerperium ending, insofar as it concerns the patient admitted for delivery, with discharge from the hospital.

Delivered in hospital - to include mothers for whom the pregnancy has terminated in the hospital, regardless of whether the infant is a live birth or a fetal death.

Admitted after delivery - to include mothers for whom the pregnancy terminated before reaching the hospital, regardless of whether the infant is a live birth or a fetal death.

Aborted - to include mothers for whom the pregnancy has terminated under the time specified by your health agency for a viable infant.

Not delivered - to include pregnant women admitted for a condition of pregnancy but not delivered of a liveborn or stillborn infant in the hospital. Under this heading will come threatened abortions which have been prevented from terminating, false labors, deliveries outside the hospital brought in for the puerperium, retained placentas, postpartum hemorrhages, lactating breasts, and other puerperal conditions.

ORTHOPEDICS: diseases and conditions of the bones, joints, muscles, fasciae, tendons, and their nerve control which affect motion and are not acutely traumatic in nature. If a traumatic count is kept, all new fractures should be entered under traumatic surgery and old fractures in orthopedics. If a fracture count is made, both would be counted fractures.

PEDIATRICS: (children) - diseases and conditions of children under 14 years of age, unless included in one of the special services (except newborn infants born in the hospital). Newborn infants brought to the hospital after delivery are counted in this classification.

PLASTIC SURGERY: cases of surgery concerned with repair for the restoration of deformed or mutilated parts of the body, often involving transfer of tissue from one part of the body to another.

PROCTOLOGY: diseases and conditions of the rectum, anus, and sigmoid colon, unless they are a part of the disease syndrome of the female generative organs.

DISEASE CLASSIFICATION - 3

PSYCHIATRY: to include all cases of mental disorder.

SURGERY: diseases and conditions treated by manual or mechanical means except those which are assigned to a subspecialty. Breast surgery is counted under surgery.

THORACIC SURGERY: diseases of the chest in which surgery of any type is performed.

UROLOGY: diseases and conditions of the male genitourinary organs and the female urinary organs, unless the latter are a part of the disease syndrome of the female generative organs.

PROGRAMMED SERVICE ANALYSIS

1 Case #94217

Begin here

Do not look at answer below until you have completed Frame 1.

Patient is a 57-year old female who was admitted to the hospital with the chief complaint of difficulty in breathing. She has a long history of emphysema and asthma, and has been admitted to this hospital frequently for treatment of acute asthmatic attacks. The most recent admissions were in May and June of this year. The present attack began about three days prior to admission, during the time of a high wind and severe dust storm. The patient has also noted an increase in edema of the legs; this has been aggravated the past two nights prior to admission because the patient has had to sit up in order to breathe, with her legs hanging over the side of the bed. She had apparently taken a chill also during this time, and at the time of admission she is having chills and fever. The patient is being readmitted for observation and treatment. In addition, she has a back condition which requires the use of an orthopedic bed. Past history reveals that approximately 25 years ago the patient was exposed to a heavy concentration of dust while living in Mexico. She states that at that time her lungs were so badly damaged and irritated that she has had asthma and emphysema ever since that time. She has also been treated for mild cardiac decompensation and edema for the past three years.

1 2 Case #94976

MEDICINE

MEDICINE

This 32-year old adult male is admitted for revision of burns of both hands. Approximately five months ago, the patient sustained a severe burn of both hands when he fell into a bucket of hot tar used in roofing, to the area of approximately the elbows. He has responded quite satisfactorily to primary graft, although some keloid formation is present. Range of motion in both hands is satisfactory; strength is, of course, decreased, but outlook possibly is not too severe. Because of strictures in the webs in the digits

of the left hand, and the third and fourth digit on the right hand, together with the thenar aspect of the left hand, the patient is admitted for skin grafting and plastic revision. There is also superficial laceration and cracking about the olecranon on the right elbow.

2 3 Case #94807

SURGERY

SURGERY

This 24-year old male was involved in an automobile accident in California on May 14, 1969, and was treated there at that time. He had the right leg externally rotated at the time of the accident, and he was thrown under the dash board with a strong valgus force being applied to the right knee. Since then he has had episodes where the right knee "gives out." When he describes this sensation he indicates something shifting out of position along the medial aspect of the joint. Apparently this is not the patella. He forces the knee into hyperextension and there is an audible click and a sensation of something shifting in position deep within the knee, and the sensation of being out of place is relieved. He has difficulty in flexing the knee, but no pain. He has no difficulty in extending. He has had some discomfort on the lateral aspect as well as the medial. He was seen by me for the first time in June, and examination at the time suggested some springiness of the medial collateral ligament, although this is not conformed by stress films. On examination in the past he demonstrated what appears to be a definite McMurray's click, as well as the springiness and apparent slight laxity of the medial collateral ligament. He is admitted now for arthrotomy with exploration of the collateral ligament in addition.

3 4 Cast #95628

SURGERY

ORTHOPEDICS

This 40-year old white female is admitted to the hospital with a severe vaginal hemorrhage. Prior to admission to the hospital, within a half hour, she had soaked twelve perineal pads and had soaked a towel on admission. She had had some cramping. The patient's menstrual periods have been extremely

irregular throughout her life. She often menstruated at six-month intervals. For the past several years, however, she has been on a birth control pill, and even with taking this she rarely menstruates. Her last menstrual flow was in April, but again this was not unusual. The patient is now in her second pill of this cycle. Past history indicates that the patient has had three full term pregnancies with three living children. She has had two late abortions and one missed abortion.
Addendum: Recent pregnancy test was positive, but a pregnancy test done since admission to the hospital was reported as negative. She has continued to bleed profusely, and is to be taken to Surgery within the hour for an emergency D & C.

4 5 Case #95595

OB - ABORTED

OB - ABORTED

This is the first admission to this hospital of this 11-year old girl, having developed headaches and some weakness over the last three or four days. She had been vomiting two days prior to admission, and was seen at the office the day prior to admission. She had been noted to be quite pale and also to have a little puffiness of the eyelids, the last several days prior to admission. The examination at the office did show her to be quite pale and her pulse was 108 per minute. A urine specimen showed some 45 to 55 white blood cells and a hematocrit of 19% with a hemoglobin of 5.6, so it was thought advisable to admit her for further evaluation and treatment. She has also had a mild diarrhea of several days prior to admission. This young girl has had several previous urinary tract infections, and was evaluated in Minnesota in 1961 for the recurring urinary tract infections. She had cystoscopy and retrograde x-ray studies made which showed no evidence of any obstructive uropathy. She was noted to have a bilateral duplication of the kidneys, with it being an incomplete duplication on the left. The voiding cystogram at that time showed no evidence of reflux. She did have a urinary tract infection in July, 1968 for which she was treated with Furadantin for two weeks, following which she did seem to get along

fairly well until she had another episode in December of 1968 which was also treated with Furadantin. Since that time she has had no subsequent urinalysis check.

5 6 Case #94532

MEDICINE

UROLOGY

This 83-year old male was in the hospital in June of this year for cataract extraction on the left eye. He had had bilateral cataracts for some time, the left being worse than the right. He has had a high amount of near-sightedness and astigmatism, and was referred by his local physician for removal of the cataracts on both eyes. He comes in at this time for surgery on the right eye. He has good light projection. The tension in both eyes is normal. Corneas appear to be in good condition. Nerve head, what I can see of it, looks all right. There does not appear to be a macular problem. There is no change in his physical condition this past month since his previous surgery; in fact, his wife reports that he has been in better spirits and health than before. Results of first surgery 20/20 with glasses.

6 7 Case #94350

SURGERY

OPHTHALMOLOGY

The patient is a 42-year old male who states that he was hauling hay when he noted that a shed nearby in which some youngsters were playing had caught fire. He entered the shed and immediately his clothing caught on fire. As a result, he suffered second and third degree burns of the legs. He was seen in the Emergency Room where dressings were applied and he was admitted to the hospital. While in Emergency, examination revealed that approximately 60% of the legs was involved.

7 8 Case #94565

SURGERY

SURGERY

Patient is a 45-year old white female who enters the hospital with the chief complaint of varicose veins of the right leg, of several years duration. Patient states that she has had progressively increasing varicose veins, with no definite recent accentuation of symptoms. The veins have been

relatively asymptomatic. She denies swelling, aching, muscle spasm or previous episodes of phlebitis. There is no history of stasis dermatitis, pruritis, stasis ulceration, or other evidence of deep venous insufficiency. There is a previous history of a local ligation and injection of veins on the medial aspect of the right calf.

8 9 Case #94203

SURGERY

SURGERY

This 15-year old boy was riding his motorcycle near Teton, Idaho about ten o'clock this morning when a car pulled out in front of him, and he was unable to miss the car and ran into it. He was thrown from the motorcycle and sustained open injury to the right leg. He was wearing a crash helmet and was not unconscious. He was taken to a nearby hospital where the examining physician expressed concern over the vascular status of the leg. He splinted the leg and transferred the patient to this hospital to the care of a Cardio-vascular Surgeon and an Orthopedic Surgeon. On arrival, examination demonstrated palpable posterior tibial pulse; and in addition there was an open injury to the dorsum of the foot and the leg was in a splint. His pressure has been maintained stable in the range of 120/60. He had received Demerol and Vistaril before being transferred. He is being taken to Surgery for treatment of the compound fracture of the right leg. He has not eaten since 7:00 o'clock this morning.

9 10 Case #94634

SURGERY

TRAUMATIC SURG.

This 32-year old white male has been under the care of his Psychiatrist for some time, and had been a patient in the Psychiatric Unit at the Blank Hospital. The week prior to his admission here, he apparently had left there against the advice of his physician. This evening, he apparently took an overdose of medication and was brought to the Emergency Room where he was lavaged and admitted to the hospital. He will be transferred back to the Psychiatric Unit in the morning. On questioning, the patient is rather vague in his answers but states that his

depression dates back perhaps two to three years. Patient is a mechanical engineer, is married, has six children ranging in age from one to nine, and has lived in this city for four years. It is felt that patient is dangerous to himself, and possibly to others, and he will be observed closely until transfer can be made for further psychiatric evaluation and care.

10 11 Case #93621

MEDICINE

PSYCHIATRY

This 42-year old male, grocery merchant, is admitted for investigation of generalized lymphadenopathy. Patient has been in this hospital on numerous occasions because of low back problems, and last year was operated for a herniated nucleus pulposus in the low back. Patient was seen in my office on January 30th, complaining of a right-sided sore throat for about one month, with pain on swallowing but no sensations of postnasal drip. At that time, the patient's temperature was normal. He had an enlarged cervical node on the right. Pharynx was not remarkable. He was given a course of Polycillin and Triaminic. Patient was again seen on February 4th stating that he had gotten a recurrence of his sore throat, and developed huge nodes in his neck. Again, it was painful to swallow. At this time, the patient's temperature was again normal. He had some large nodes in the right side of the neck and into the supraclavicular area. No splenic enlargement could be found. The patient was sent to the Lab. for a white blood count and heterophile, and a P.A. of the chest was ordered. The heterophile and the Mono. test were negative. Patient's white count was 9,750 with 44 neutrophils, 51 lymphs, 4 monos, and 17 of the lymphocytes were called atypical. X-ray of the chest was interpreted as normal.

Patient's condition improved somewhat. The nodes decreased in size, and some of them disappeared. About two weeks ago, the patient developed a recurrence of his low back pain, and then developed marked increase in swelling of nodes in both axillae, both sides of the neck, and in the left supraclavicular area. Patient was bedfast with rather severe low back

back pain, so did not come to the office. The Lab. made a trip to his home and obtained blood for another white count and heterophile. The heterophile was negative but the white count again showed extremely large atypical lymphocytes. Patient was then admitted to the hospital for further laboratory workup, and consultation was requested.

During the course of the patient's hospitalization, a bone marrow aspiration and supraclavicular node biopsy were accomplished, confirming the diagnosis of lymphosarcoma.

11 12 Case #94804

MEDICINE

CANCER

This 51 year old female is admitted to the hsopital for a cholecystectomy. She gives a history of indigestion and an attack of quite severe pain approximately 2-3 weeks ago which lasted 24-36 hours, and associated with some nausea and vomiting. She stated that her urine was dark at that time, but that she did not notice any yellowness in her skin or eyes. She has had some indiges tion on and off, but no severe pain until this attack. Patient was seen in the office. Her x-rays revealed cholelithiasis, and she is admitted at this time for cholecystectomy. There are no other complaints.

12 13 Case #94376

SURGERY

SURGERY

Patient is an elderly white male who enters the hospital through the Emergency Room with a chief complaint of severe pain in his right lower extremity, numbness of the right foot and lower leg, coldness and pallor beginning at 10:00 a.m. on the day of admission. Patient gives a past history of rheumatic heart disease with mitral stenosis previously diagnosed in 1963. At that time, he also had a severe hypertension, running in the range of 240/120. At his request, he was referred to the Veterans Administration Hospital for evaluation and treatment. At that time, he also had an episode of severe ischemia to the right lower extremity from which he had recovered by the time he entered the V.A. Hospital. Patient was seen at V.A. by the Cardiology team, and diagnostic studies

were recommended for his heart and peripheral vascular disease. He declined these and was discharged home on antihypertensive medications. Since that time, he has had occasional episodes of vascular insufficiency to the right lower extremity, but has not sought medical assistance. He states that he has been in good health otherwise. He has had no recent illnesses or infections. Examination at this time reveals that the right lower extremity is cool, pale and slightly mottled from the upper calf distally, with suggestion of impending gangrene. It is planned to do a thrombectomy of the right femoral arteries.

13 14 Case #94215

SURGERY

SURGERY

This 49-year old male Optometrist was seen in the Emergency Room on the day before this admission, complaining of chest pain which had started while he was doing some spackling work on a wall at home. This pain had started without warning and was described as a heavy aching distress in the upper sternal area, radiating upward into the neck and jaws and ears bilaterally, and was subsequently relieved by Nitroglycerin given to him by another physician. Associated with this he has had no dyspnea, sweating, or cough, and had noted no previous symptoms similar to these in the days before. Seen in the Emergency Room, the electrocardiogram was found to be normal, his vital signs were within normal limits, heart tones were good, and the rhythm was regular. He was given a prescription for Isordil to take at home and advised to stay on bedrest for the next two or three days to observe changes. On the morning of this admission, he called, stating that he had started to have pain again after he went home and the pain had persisted during the entire night, not relieved by Nitroglycerin. Although it had been described as severe and heavy, it was not excruciating and he did not call for help until the morning hours. He states that the pain now that he feels is only in the upper chest region, and is not felt in the jaws or neck. Six years ago, he had an episode of anginal distress manifested by aching jaws and neck without chest pain, diagnosed as coronary insufficiency and treated with Persantine.

Since that time he has had no particular trouble unless he exerted himself heavily, such as mowing the lawn too rapidly. At that time he would feel pain in the neck and jaws, and would find that this was relieved by stopping the activity. He has played golf and been active in his garden and walking during these six years without difficulty. He is being admitted at this time for further evaluation and treatment.

14 15 Case #95545

MEDICINE

MEDICINE

This two-month old Spanish-American child was apparently well until three days prior to admission at which time, in the late evening, he began to have difficulty in breathing and was noted to be wheezing. Accordingly the following morning at 5:00 a.m. he was admitted to a nearby hospital where the clinical diagnosis of croup was made. He was kept in the hospital and began to show improvement this morning, when the mother insisted that the child be taken from the hospital for financial reasons. Upon returning home, the mother stated he ate very poorly and seemed to be having abdominal pain; and in the early afternoon, once again he began to have difficulty in breathing, so was readmitted to the same hospital. However, as the day progressed he began to have increasing difficulty in his breathing, apparently having some dyspnea, and was transferred to this hospital for further intensive treatment.

15

MEDICINE

PEDIATRICS

RECOMMENDED REFERENCE BOOKS & PERIODICALS

1. MANUAL FOR MEDICAL RECORD LIBRARIANS, 5th ed.
   by Edna K. Huffman, RRL $10.00
2. LEGAL ASPECTS OF MEDICAL RECORDS, - Hayt & Hayt - $12.50
3. ANATOMY FOR THE MEDICAL RECORD LIBRARIAN - Thompson & Hayden $12.75
4. MEDICAL RECORD PROCEDURES IN SMALL HOSPITALS -- McNabb, RRL
5. MEDICAL TERMINOLOGY MADE EASY -- JeHarned Bufkin, RRL

(Address): Physicians' Record Co.
3000 S. Ridgeland Ave.
Berwyn, Illinois 60402

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6. MEDICAL RECORD NEWS (Journal of the American Medical Record Assoc.) $6
7. GUIDE TO THE ORGANIZATION OF A HOSPITAL MEDICAL RECORD DEPARTMENT $2
8. SYSTEMS CONCEPTS & DATA PROCESSING: AN INTRODUCTION $2

(Address): AMRA Publications Department
American Medical Record Association
211 East Chicago Avenue
Chicago, Illinois 60611

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9. UNIFORM CHART OF ACCOUNTS & DEFINITIONS FOR HOSPITALS

(Address): American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

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10. UNDERSTANDING MEDICAL TERMINOLOGY - Sister M. Agnes Clare, SSM,RRI
11. MEDICAL CASE RECORD ANALYSIS - Sister M. Servatia, RRL

(Address): Catholic Hospital Association
St. Louis, Missouri

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12. CURRENT MEDICAL TERMINOLOGY, 3rd ed.

(Address): Circulation & Records Dept.
American Medical Association
535 N. Dearborn
Chicago, Illinois

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13. HANDBOOK ON MEDICAL TERMINOLOGY - edit. by Jean Marks, RRL

(Address): Marks Publishing Service, P. O. Box 4744
Redford Station, Detroit, Michigan 48219

RECOMMENDED REFERENCE BOOKS & PERIODICALS - 2

14. A SYLLABUS FOR THE SURGEON'S SECRETARY - Jeannette A. Szulec, B.S., RRL

(Address): Medical Arts Publishing Co.
P.O.Box 130 Kensington Sta.
Detroit, Michigan 48224

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15. STANDARDS FOR ACCREDITATION OF HOSPITALS -

(Address): Joint Commission on Accreditation of Hospitals
645 North Michigan Ave.
Chicago, Illinois 60611